WYOMING LEGISLATIVE SERVICE OFFICE

Short Report

WYOMING MEDICAID FRAUD: DETECTION, INVESTIGATION, PROSECUTION AND OUTCOMES

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EXECUTIVE SUMMARY

Federal regulations require state Medicaid agencies to identify suspected Medicaid fraud and program abuse cases and refer suspected fraud cases to the state Medicaid fraud control unit or an appropriate law enforcement agency. In Wyoming, the Department of Health, Program Integrity Unit identifies and seeks to recover Medicaid overpayments. The Unit refers suspected Medicaid provider fraud cases to the Wyoming Medicaid Fraud Control Unit (MFCU) within the Office of the Attorney General. The Program Integrity Unit is in the process of assuming responsibility for the investigation of suspected Medicaid client fraud from the Department of Family Services. Suspected Medicaid client fraud is referred for prosecution to the county attorney of the county in which the client resides.

States are required to return the federal share of recovered Medicaid overpayments and Medicaid civil and criminal restitutions. The percentage of state Medicaid funding eligible for federal matching funds is referred to as a state's federal medical assistance percentage or FMAP. Wyoming's FMAP is 50 percent, therefore 50 percent of recovered Medicaid overpayments and Medicaid civil and criminal restitutions must be returned to the federal Centers for Medicaid and Medicare Services.

In SFY 2021, the Department of Health's Program Integrity Unit identified $201,525 in Medicaid overpayments, referred approximately $3.3 million in suspected fraud payments for investigation by the State MFCU or other law enforcement, and received $385,243 in payments from identified overpayments and court judgments.

At the end of FFY 2021, the Wyoming MFCU had 11 open Wyoming Medicaid provider fraud investigations and four open Wyoming false claims civil cases, and was involved with 31 open multi-state civil claims. In FFY 2021, Wyoming criminal prosecutions and civil actions resulted in judgments totaling $1,642,498. Multi-state civil actions in FFY 2021 awarded the State an additional $259,645. Dollars recovered by the State in FFY 2021 totaled $1,633,723 ($778,136 federal share; $855,587 State share).

Under a federal incentive program, states that enact false claims acts modeled on the federal False Claims Act may qualify for a ten percent decrease in the share of monies recovered under the state act that must be repaid to the federal government. One of the key provisions of the federal False Claims Act with which state acts must comply is a *qui tam* provision that allows a whistleblower with evidence of Medicaid fraud to bring a civil action on behalf of the government. Wyoming's False Claims Act currently lacks such a provision. Should Wyoming choose to amend the State False Claims Act to qualify for the federal incentive, Wyoming could retain 60 percent of monies recovered under the Act.

INTRODUCTION[1]

Medicaid is a federal-state partnership. States administer their Medicaid programs within federal and state guidelines and receive federal matching funds for state dollars spent. State Medicaid programs and the U.S. Department of Health and Human Services (DHHS), Centers for Medicaid and Medicare Services (CMS) share responsibility for ensuring state and federal dollars are used to deliver quality health care services with efficiency and economy to eligible individuals and are not misused for fraud, waste, or abuse.

Medicaid fraud is prohibited by federal and state civil and criminal laws. Federal laws addressing Medicaid fraud and related activities include the:[2]

- civil False Claims Act, 31 U.S.C. 3729-3733
- criminal False Claims Act, 18 U.S.C. 287
- Anti-Kickback Statute, 42 U.S.C. 1320a-7b(b)
- Physician Self-Referral Law (a.k.a. the Stark Law), 42 U.S.C. 1395nn
- Exclusion Statute, 42 U.S.C. 1320a-7
- Civil Monetary Penalties Law, 42 U.S.C. 1320a-7a

Wyoming has enacted two statutes addressing Medicaid fraud. The Medicaid False Claims Act, passed in 2013, establishes civil liabilities for Medicaid providers or Medicaid recipients who knowingly submit false or fraudulent Medicaid claims.[3] The Medicaid Fraud Control Act, passed in 2019, establishes criminal penalties for Medicaid providers who knowingly submit false or fraudulent claims, accept kickbacks or bribes, or fail to maintain records with regard to Medicaid claims.[4]

Medicaid fraud is investigated and prosecuted at both the federal and state level. At the federal level, Medicaid overpayments and suspected fraud are investigated by a variety of agencies, including CMS, the DHHS Office of Inspector General, the Department of Justice, the Federal Bureau of Investigation, and Unified Program Integrity Contractors.[5] Unified Program Integrity Contractors (UPICs) are CMS-contracted entities that conduct investigations and audits in an effort to reduce fraud, waste, and abuse in the Medicaid and Medicare programs.[6] The UPICs operate in

[1] **CMS, Comprehensive Medicaid Integrity Plan for FFY 2019-2023**.
[2] **DHHS Office of Inspector General (OIG), Fraud & Abuse Laws webpage**, accessed August 2022.
[3] W.S. 42-4-301 through 42-4-306.
[4] W.S. 42-4-401 through 42-4-412.
[5] **CMS, Healthcare Fraud Prevention Partnership webpage, accessed August 2022**.
[6] **CMS, Medicaid Program Integrity Manual, Chapter 1—Medicaid Integrity Program, issued October 9, 2020**.

five separate geographic areas or jurisdictions.[7] The CMS contractor for the UPIC Western Jurisdiction, which includes Wyoming, is Qlarant Integrity Solutions, LLC.[8]

At the state level, federal regulations require state Medicaid agencies to identify suspected Medicaid fraud and program abuse cases and refer suspected fraud cases to the state Medicaid fraud control unit or an appropriate law enforcement agency.[9] State and federal agencies often collaborate in Medicaid fraud investigations by participation in Major Case Coordination groups, which serve as the UPIC's forum to present and refer suspected fraud cases to the DHHS Office of Inspector General.[10] In Wyoming, the Department of Health's Medicaid Program Integrity Unit and the Attorney General's MFCU participate in a Major Case Coordination group that includes CMS, the DHHS Office of inspector General, and the UPIC contractor, Qlarant.[11]

WYOMING MEDICAID FRAUD AND FALSE CLAIMS STATUTES

Medicaid fraud is addressed by two Wyoming statutes: the False Claims Act, which establishes civil liabilities, and the Fraud Control Act, which establishes criminal penalties.

WYOMING FALSE CLAIMS ACT [12]

In 2013, the Legislature enacted the False Claims Act which authorizes the MFCU or a district attorney to investigate alleged Medicaid false claims and bring a civil action on behalf of the State. The Act establishes liabilities for Medicaid providers and Medicaid recipients who submit false or fraudulent claims:

- ***Medicaid providers*** who knowingly submit or conspire to submit a false Medicaid claim are liable for three times the amount of damages the State sustained plus a civil penalty of $1000 to $10,000.
- ***Medicaid recipients*** who knowingly submit a false claim are liable for the amount of damages the State sustained and a civil penalty of not more than $1000. However, Medicaid recipients who commit a violation of the Act a second or subsequent time, are liable for treble damages in addition to a civil penalty of not more than $1000.

WYOMING FRAUD CONTROL ACT[13]

In 2019, the Legislature enacted the Fraud Control Act which recognizes and continues the existence of the Attorney General's Medicaid Fraud Control Unit (MFCU), previously established by executive order of the Governor in 1994. The Act specifies the duties of the MFCU and requires the Department of Health, Department of Family Services, health care licensing boards, and State

[7] Ibid.
[8] **CMS, Research Statistics, Data & Systems, Review Contractor Directory—Interactive Map, accessed August 2022**.
[9] 42 CFR 455.13 and 455.15.
[10] Information provided by the Wyoming Department of Health, July 2022.
[11] Ibid.
[12] W.S. 42-4-301 through 42-4-306.
[13] W.S. 42-4-401 through 42-4-412.

agencies and contractors to refer to the MFCU all suspected cases of (a) Medicaid provider fraud, waste, abuse, bribery or kickbacks or (b) Medicaid patient abuse, neglect or exploitation.

The Act establishes criminal penalties for three types of acts related to Medicaid claims:

- Fraud and false statements;
- Kickbacks, bribes, undisclosed payments, referral fees and illegal copayments; and
- Failure to maintain records or destruction of records.

Criminal penalties for these acts vary from a misdemeanor to a felony, depending upon the act committed or the claim amount. See **Table 4** for a summary of criminal penalties and punishments.

Table 4. Medicaid Fraud Control Act Criminal Penalties and Punishments

Criminal Act	Misdemeanor		Felony
Fraud or false statement	Claim < $1000. Punishment: Up to 6 months imprisonment and/or maximum fine of $750.		Claim > $1000. Punishment: Up to 10 years imprisonment and/or maximum fine of $10,000.
Kickbacks, bribes, undisclosed payments, referral fees and illegal copayments	N/A		All violations considered a felony. Punishment: Up to 5 years imprisonment and/or maximum fine of $10,000.
Failure to maintain records or destruction of records	Claims for which records not maintained < 25% of claims and amount of claims < $5000. Punishment: up to 30 days imprisonment and/or maximum fine of $750.	Claims for which records not maintained > 25% of claims and amount of claims > $5000. Punishment: up to 6 months imprisonment and/or maximum fine of $1000.	Intent to defraud and claims for which records not maintained > 25% of claims and amount of claims > $5000. Punishment: up to 5 years imprisonment and/or maximum fine of $10,000.

Source: W.S. 42-4-406 through 42-4-408.

The Act also allows the Department of Health or the Department of Family Services to suspend or exclude a Medicaid provider from providing services or supplies if the Department determines the provider has committed an offense under the Fraud Control Act or the False Claims Act or the provider fails to provide the MFCU with access to records.[14]

[14] W.S. 42-4-410.

STATE DETECTION AND INVESTIGATION OF MEDICAID FRAUD

The Wyoming Department of Health, Program Integrity Unit is responsible for the detection and preliminary investigation of Medicaid fraud. The Unit must comply with federal regulations that govern what actions the Unit may take if fraud is suspected.

FEDERAL REQUIREMENTS FOR STATE FRAUD DETECTION AND INVESTIGATION PROGRAMS [15]

Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) regulations require a state Medicaid agency to identify suspected Medicaid fraud and program abuse cases and refer suspected cases to the state Medicaid fraud control unit or an appropriate law enforcement agency.[16] If the state agency receives a complaint of Medicaid fraud or program abuse from any source or identifies any questionable practices, the state agency must conduct a preliminary investigation to determine whether a full investigation is warranted.[17] If the preliminary investigation findings indicate an incident of fraud or program abuse has occurred, the regulations require the state agency to take one of three actions:[18]

- ***Medicaid provider suspected of fraud or program abuse:*** the state agency must refer the case to the state Medicaid fraud control unit;
- ***Medicaid beneficiary suspected of fraud****:* the state agency must refer the case to an appropriate law enforcement agency; or
- ***Medicaid beneficiary suspected of program abuse:*** the state agency must conduct a full investigation of the abuse.

The regulations define fraud and abuse as follows:[19]

> ***Fraud****:* an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. Includes any act that constitutes fraud under applicable federal or state law.
>
> ***Provider program abuse****:* practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.
>
> ***Beneficiary program abuse****:* practices that result in unnecessary cost to the Medicaid program.

[15] 42 CFR 455 Program Integrity: Medicaid
[16] 42 CFR 455.13 and 455.15.
[17] 42 CFR 455.14.
[18] 42 CFR 455.15.
[19] 42 CFR 455.2

If the state agency determines there is a credible allegation of provider fraud, the agency must suspend all Medicaid payments to that provider to prevent further "bleed" of Medicaid funds until the agency or prosecuting authorities determine there is insufficient evidence of fraud or legal proceedings are completed.[20] Credible allegation of fraud is defined as an allegation, verified by the State, from any source, including:[21]

- Fraud hotline tips verified by further evidence;
- Claims data mining; [22]
- Patterns identified through provider audits, civil false claims cases, and law enforcement investigations.

Federal regulations allow an exception to provider payment suspension if a state finds good cause not to suspend payments.[23] For instance, law enforcement wishing to catch a provider "in the act" of fraud may request payments not be suspended to prevent alerting the provider of an ongoing investigation.[24]

WYOMING MEDICAID PROGRAM INTEGRITY [25]

As the State Medicaid agency, the Wyoming Department of Health is responsible for the identification, preliminary investigation, and referral of suspected fraud and program abuse cases. The Department's Division of Healthcare Financing, Program Integrity Unit conducts these functions. The duties of the Unit include prevention, investigation, education, audit, recovery of improper payments, and coordination with the Wyoming Medicaid Fraud Control Unit and other federal/local law enforcement agencies.

The Program Integrity Unit is comprised of eight full-time staff: a manager, three supervisors, and four analysts. The Unit is funded by 50 percent State general funds and 50 percent federal funds. Annual program costs in 2021 were $761,840. See **Table 1,** below, for Unit expenditures, 2019 through 2021.

Table 1. Program Integrity Unit Expenditures (50% State; 50% Federal funds)

2019	2020	2021
$711,197	$634,988	$761,840

Source: Wyoming Department of Health, Program Integrity, SFY 2021 Program Snapshot

[20] 42 CFR 455.23.
[21] 42 CFR 455.2.
[22] Data mining is the practice of electronically sorting Medicaid or other relevant data, including but not limited to the use of statistical models and intelligent technologies, to uncover patterns and relationships within that data to identify aberrant utilization, billing, or other practices that are potentially fraudulent. 42 CFR 1007.1.
[23] 42 CFR 455.23.
[24] 42 CFR 455.23.
[25] Department of Health Rules, Ch. 16, Medicaid Program Integrity; WDH Program Integrity, SFY 2021 Program Snapshot; and information provided by the WDH Program Integrity Unit Manager.

Overpayment Identification and Recovery[26]

To identify Medicaid overpayments and suspected fraud and program abuse, the Program Integrity Unit may conduct an:

- Audit of providers or clients;
- Random sample provider claims review and extrapolation; or
- Review of all claims submitted by a provider for the past six years.

If an overpayment is discovered, the Program Integrity Unit sends written notice to the provider or client who received the overpayment. The provider or client is required to reimburse the Department of Health within 30 business days of receipt of the notice. If the provider or client does not reimburse the Department, the Department is required to recover the overpayment by withholding all or part of future Medicaid payments, initiating a civil lawsuit against the provider or client, or pursuing other methods of debt collection. However, a provider or client who wishes to dispute the Department's overpayment request or other adverse action may request Department reconsideration or an administrative hearing.

Federal regulations require states to refund the federal share of any identified Medicaid overpayments to CMS within one year of discovery of the overpayment, regardless of whether the state has succeeded in recovering the overpayment.[27] The only exception to this requirement is if the Medicaid provider who received the overpayment files bankruptcy or goes out of business before the end of the one-year period.[28]

The WDH Program Integrity Unit identified approximately $200,000 in overpayments in 2021. Over the previous five year period, the Unit identified annual overpayment amounts ranging from $44,391 in SFY 2019 to $1.28 million in SFY 2016. See **Table 2,** below, for overpayments identified SFY 2016 through SFY 2021.

Suspected Provider Fraud[29]

In addition to identifying and recovering overpayments, the Program Integrity Unit investigates suspected provider fraud, waste, and abuse. The Unit reports suspected provider fraud is often identified as a result of Medicaid claims data mining. Through data mining, the Unit is able to identify suspicious activity, such as repetitive billing patterns or atypical billing code submissions. Should the Unit suspect provider fraud, the Unit typically conducts a preliminary investigation that may include examination of medical, financial or patient records, interviews

[26] Department of Health Rules, Ch. 16, Medicaid Program Integrity; and WDH Program Integrity, SFY 2021 Program Snapshot
[27] 42 CFR 433.312.
[28] 42 CFR 433.318.
[29] Department of Health Rules, Ch. 16, Medicaid Program Integrity, Section 10 and Section 12; and information provided by the WDH Program Integrity Unit Manager.

with providers or clients, verification of provider credentials, examination of prescriptions, or random sampling and extrapolation. If the preliminary investigation indicates a full investigation is warranted, the Unit refers the case to the State Medicaid Fraud Control Unit. The Unit may also refer the case to the U.S. Attorney's office. In addition to referring the case, the Unit may take adverse action against the provider by suspending further Medicaid payments.

Suspected Client Fraud[30]

Historically, suspected Medicaid client fraud was referred to the Department of Family Services Eligibility Integrity Unit for investigation. The Department of Health Program Integrity Unit is currently in the process of assuming responsibility for investigation of suspected client fraud. Once this transition is complete, anticipated in December 2022, the Program Integrity Unit will conduct full investigations of suspected client fraud. Under current Department of Health rules, a Medicaid client who commits fraud, waste, or abuse in obtaining services may be subject to any of the following adverse actions:

- Referral to educational intervention to correct inappropriate utilization of services;
- Recovery of overpayments;
- Restriction of future participation in Medicaid; or
- Any other action allowed by state or federal law.

The Program Integrity Unit may also refer Medicaid clients suspected of fraud to the county attorney in the county in which the client resides.

Program Integrity Unit Performance Data[31]

From SFY 2016 to SFY 2021, the Program Integrity Unit identified a total of $3 million in Medicaid overpayments and referred a total of $13.5 million in suspected fraudulent Medicaid payments to law enforcement for further investigation. Typically there is a significant lag between the identification of Medicaid overpayments or suspected fraudulent payments and the recovery of funds. Administrative recovery of identified overpayments can take up to a year or more. Investigation of suspected fraud, criminal prosecution and civil actions can take even longer. The Unit reports the recovery of overpayments and receipt of court-ordered payments often takes multiple years.

From SFY 2016 to SFY 2021, judgments from civil false claims settlements and court-ordered restitution from successful criminal prosecution of cases referred by the Program Integrity Unit to law enforcement totaled $8.5 million. Actual payments received from identified overpayments,

[30] Department of Health Rules, Ch. 16, Medicaid Program Integrity, Section 11 and Section 13; and information provided by the WDH Program Integrity Unit Manager.
[31] WDH Program Integrity, SFY 2021 Program Snapshot; and information provided by the WDH Program Integrity Unit Manager.

criminal and civil judgments totaled $1.8 million, with annual payment amounts varying from $194,052 in SFY 2020 to $409,591 in SFY 2016. See **Table 2** for a summary of identified overpayments, fraud referrals, court judgments, and payments received, SFY 2016 – SFY 2021.

Table 2. Program Integrity Outcomes Data, SFY 2016 – SFY 2021

Performance Metric	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	TOTAL
Overpayments identified and recovery attempted by PI Unit	$1,275,227	$845,648	$469,242	$44,391	$238,021	$201,525	$3,074,054
Suspected fraud payments referred to external partners[32]	$8,713,451	$0	$0	$1,500,000	$0	$3,302,887	$13,516,338
Court judgment amounts from false claims settlements and criminal restitution from cases referred by PI Unit	$0	$0	$2,270,304	$6,247,914	$0	$0	$8,518,218
Overpayments identified by the Unified Program Integrity Contractor (UPIC)	$0	$0	$4,429,605	$66,605	$0	$0	$4,496,210
Payments received from identified overpayments and court judgments (excluding Global Settlement[33] amounts).	$409,591	$399,760	$104,579	$338,962	$194,052	$385,243	$1,832,187

Source: WDH Program Integrity, SFY 2021 Program Snapshot

STATE PROSECUTION OF MEDICAID PROVIDER FRAUD

The Medicaid Fraud Control Unit (MFCU) within the Wyoming Office of the Attorney General investigates and prosecutes Medicaid provider fraud. The MFCU is overseen and largely funded by the DHHS Office of Inspector General.

FEDERAL REQUIREMENTS FOR STATE MEDICAID FRAUD CONTROL UNITS [34]

In 1993, Congress amended the Social Security Act to require each state to establish a Medicaid Fraud Control Unit (MFCU) by January 1, 1995.[35] The function of MFCUs is to investigate and prosecute Medicaid provider fraud and patient abuse and neglect. Currently, all 50 states and the

[32] External partners include the Wyoming Medicaid Fraud Control Unit or other law enforcement, the federal Unified Program Integrity Contractor (UPIC), or the U.S. Attorney's Office.
[33] Global Settlement cases are those litigated by the National Association of Medicaid Fraud Control Units.
[34] 42 CFR 1007 State Medicaid Fraud Control Units; and U.S. Department of Health and Human Services, Office of Inspector General (DHHS-OIG), Medicaid Fraud Control Units Fiscal Year 2021 Annual Report.
[35] Wyoming Executive Order 1994-10.

District of Columbia operate MFCU units, which are typically part of the state attorney general's office.

State MFCUs are jointly funded by the federal and state governments. Each MFCU receives a federal grant to fund 75 percent of expenditures; the remaining 25 percent is funded with state monies.[36]

The Department of Health and Human Services, Office of Inspector General (DHHS-OIG) oversees, annually recertifies, and assesses each state MFCU's performance and compliance with federal requirements. DHHS-OIG regulations require each state MFCU to be a single identifiable entity of state government, separate and distinct from the state Medicaid agency. The MFCU and state Medicaid agency are required to enter into a written agreement that includes the following provisions:

- the agency will refer all cases of suspected provider fraud to the MFCU;
- the MFCU will conduct a statewide program for investigating and prosecuting or referring for prosecution violations of all applicable state laws, criminal and civil, pertaining to Medicaid fraud;
- the MFCU will review complaints alleging abuse or neglect of patients or residents in health care facilities receiving payments under Medicaid; and
- the agency and the MFCU will regularly meet and coordinate their efforts.

DHHS-OIG regulations also require each state MFCU employ sufficient staff to perform its duties, including:

- one or more attorneys capable of prosecuting the health care fraud or criminal cases;
- one or more experienced auditors capable of reviewing financial records and advising or assisting in the investigation of alleged health care fraud and patient or resident abuse and neglect; and
- one or more investigators capable of conducting investigations of health care fraud and patient or resident abuse and neglect matters.

WYOMING MEDICAID FRAUD CONTROL UNIT[37]

In 1994, the Wyoming MFCU was established by executive order of the Governor as part of the Wyoming Attorney General's Office.[38] The MFCU was not codified in state statute until enactment of the Wyoming Medicaid Fraud Control Act in 2019.[39]

[36] New state MFCUs receive DHHS-OIG grants that fund 90% of expenditures during their first three years of operation.
[37] Wyoming MFCU, 2021 Annual Report, amended August 2022; and information provided by the MFCU Director, August 2022.
[38] Wyoming Executive Order 1994-10.
[39] 2019 SF 85.

The Wyoming MFCU currently employs four staff: an attorney who serves as the MFCU director, an investigative auditor, a law enforcement agent, and a paralegal.[40] The MFCU budget is comprised of 75 percent federal funds and 25 percent state funds. Total MFCU program costs in FFY 2021 were $396,986, with $99,246 (25 percent) contributed by the state. See **Table 3** for MFCU program costs, FFY 2017-2021.

Table 3. MFCU Program Costs, 2017 – 2021

Year	MFCU Expenditures	Federal funds (75%)	State funds (25%)
2017	$483,025	$362,269	$120,756
2018	$457,124	$342,843	$114,281
2019	$377,147	$282,860	$94,287
2020	$443,354	$332,515	$110,839
2021	$396,986	$297,740	$99,246

Source: MFCU 2021 Annual Report and information provided by the MFCU Director

The MFCU receives referrals of suspected Medicaid provider fraud cases from a variety of sources, including the WDH Program Integrity Unit, the MFCU phone hotline and online reporting system, and federal partners. The MFCU reports all cases are initially opened as criminal investigations unless referred as multi-state civil investigations. The MFCU reviews all cases for civil recovery before closing the case. Should an investigation lead to a criminal or civil action, the MFCU, in collaboration with federal partners, decides whether to pursue available remedies in State court or federal court.

Medicaid Fraud Control Unit Performance Data[41]

In FFY 2021, the MFCU received a total of 46 fraud complaints: 24 Wyoming-specific complaints and 22 multi-state complaints. According to the MFCU, multi-state investigations typically focus on large, national pharmaceutical companies or medical equipment providers, while Wyoming-specific investigations focus on in-state providers. Of the complaints received, MFCU opened 21 investigative cases, referred 14 complaints to external partners, and declined 11 complaints. See **Table 4**.

[40] **Wyoming Attorney General MFCU Unit staff listing webpage**, accessed August 2022.
[41] MFCU 2021 Annual Report, amended August 2022; and information provided by the MFCU Director, August 2022.

Table 4. Wyoming MFCU Fraud Complaints Received, FFY 2021

Type	Total Received	Opened	Referred Out	Declined
Wyoming Medicaid fraud	24	5	14	5
Multi-State Medicaid fraud	22	16	0	6
TOTAL	**46**	**21**	**14**	**11**

Source: MFCU 2021 Annual Report, amended August 2022

At the end of FFY 2021, the MFCU reported a total of 46 open fraud investigations: 11 criminal cases, four Wyoming civil cases and 31 multi-state civil cases. See **Table 5**.

Table 5. Wyoming MFCU Criminal/Civil Investigative Cases, FFY 2021

Type	Open at start of FFY	Opened during FFY	Prosecuted in FFY	Other Resolution	Closed	Open at end of FFY
Criminal Cases						
Wyoming Medicaid Fraud	16	6	3	0	11	11
Multi-State Medicaid Fraud	0	0	0	0	0	0
Criminal Subtotal	16	6	3	0	11*	11
Civil Cases						
Wyoming False Medicaid Claims	2	3	3	2	1	4
Multi-State Civil Claims	35	16	0	4	20	31
Civil Subtotal	37	19	3	6	21	35
TOTAL	**53**	**25***	**6**	**6**	**32***	**46**

* Two cases moved from criminal to civil in the fiscal year.

Source: MFCU 2021 Annual Report, amended August 2022

Wyoming and multi-state Medicaid fraud cases investigated in FFY 2021 involved a variety of Medicaid provider types, including inpatient or residential facilities, outpatient facilities, licensed practitioners, personal care services attendants, and medical service companies. See **Table 6**.

Table 6. Wyoming MFCU Cases by Provider Type, FFY 2021

Provider Type	Criminal		Civil		
	Investigations	Criminal Judgments	Investigations	Number of Settlements and Judgments	Dollar amount of Judgments
Facility-based Medicaid Providers and Programs—Inpatient/Residential					
Developmental Disability Facility (Residential)	1				
Inpatient Psych Services for Individuals Under 21	1				
Nursing Facilities			1		
Facility-based Medicaid Providers and Programs—Outpatient/Day Services					
Developmental Disability Facility (Non-residential)	1		1	1	$38,000
Mental Health Facility (Non-residential)	1		1	1	$1,500,000
Physicians (MD/DO)					
Physicians	0		0		
Licensed Practitioners					
Dentist	1				
Pharmacist			1		
Psychologist	2				
Other Practitioner	2				
Other Providers					
Personal Care Service Attendant	2	$104,498			
Medical Services					
Ambulance			1		
Billing Services			4	1	$16,913*
Durable Medical Equipment, Prosthetics, Orthotics & Supplies			2		
Lab (Clinical)			4		
Medical Device Manufacturer			2		
Pharmaceutical Manufacturer			7	3	$242,732*
Pharmacy (Retail)			9		
Other			1		
GRAND TOTAL	**11**	**$104,498**	**35**	**6**	**$1,797,645**

* Multi-state settlements

Source: MFCU 2021 Annual Report, amended August 2022

In FFY 2021, Wyoming MFCU Medicaid fraud criminal prosecutions and State civil actions resulted in civil awards of $1,538,000 and criminal restitutions of $104,498. An additional $259,645 was awarded from multi-state civil actions. See **Table 7** for a summary of Medicaid fraud judgments and actual dollars recovered to date, FFY 2017-2021.

Table 7. Medicaid Fraud Judgments and Actual Dollars Recovered, FFY 2017-2021

Year	Criminal Prosecutions		State Civil Actions		Multi-State Civil Actions		TOTAL	
	Judgments	Dollars Recovered	Judgments	Dollars Recovered	Judgments	Dollars Recovered	Judgments	Dollars Recovered
2017	$107,632	$240	$3,019	$3,019	$507,410	$47,448	$618,061	$50,707
2018	$2,283,802	$225,088	$0	$0	$160,063	$592,180	$2,443,865	$817,268
2019	$6,317,546	$10,219	$1,736	$1,736	$441,759	$456,552	$6,761,041	$468,507
2020	$0	$21,792	$0	$100	$847,122	$839,808	$847,122	$861,700
2021	$104,498	$11,238	$1,538,000	$1,538,000	$259,645	$84,484	$1,902,143	$1,633,722

Source: MFCU 2021 Annual Report, amended August 2022

Wyoming is required to return the 50 percent federal share of any recovered dollars to CMS. In FFY 2021, Wyoming's share of recovered dollars, including additional state penalties, was $855,587. See **Table 8** for State and federal shares of recovered civil and criminal judgments, FFY 2017-2021.

Table 8. State/Federal Share of Civil and Criminal Restitution and Penalties, FFY 2017-2021.

Year	Total Federal Share of Restitution*	State Share of Restitution	Additional State Penalties	Total State Dollars Recovered
2017	$21,639	$18,141	$10,927	$29,068
2018	$433,730	$316,630	$66,907	$383,538
2019	$248,132	$120,036	$100,389	$220,425
2020	$428,073	$266,612	$167,015	$433,627
2021	$778,136	$707,536	$148,051	$855,587

*Federal share includes restitution and federal penalties

Source: MFCU 2021 Annual Report, amended August 2022

POLICY CONSIDERATION: FEDERAL INCENTIVE FOR STATE FALSE CLAIMS ACTS[42]

In 2006, Congress enacted the Deficit Reduction Act which includes an incentive for states to enact anti-fraud legislation modeled after the federal False Claims Act. The federal False Claims Act, as amended in 1986, provides penalties and treble damages for anyone who knowingly submits or causes the submission of false of fraudulent claims to the United States for government funds or property. The federal Act also includes *qui tam* provisions which authorize a "relator" or whistleblower with evidence of fraud to file a case in federal court and sue, on behalf of the government, persons engaged in the fraud. Should the civil action be successful, the whistleblower receives a share of monies recovered.

States that enact qualifying false claims acts modeled on the federal Act receive a ten percent increase in the state share of any monies recovered under the state act. In order to qualify for the incentive, state false claims act must:

- Establish liability to the state for false or fraudulent claims, as described in the federal False Claims Act, with respect to Medicaid spending;
- Contain provisions that are at least as effective in rewarding and facilitating *qui tam* actions for false or fraudulent claims as those described in the federal False Claims Act;
- Contain a requirement for filing an action under seal for 60 days with review by the state Attorney General; and
- Contain a civil penalty that is not less than the amount of the civil penalty authorized under the federal False Claims Act.

While the current Wyoming False Claims Act meets some of these qualifications, including treble damage civil penalties similar to those of the federal False Claims Act, the Wyoming Act does not include a *qui tam* provision allowing a whistleblower to file a false claims case in State court. Rather, under the Wyoming False Claims Act, only the MFCU or a district attorney may initiate a false claims action.

States wishing to qualify for the federal incentive are required to submit their state false claims act to the DHHS Office of Inspector General for review. To date, 22 states, including Colorado, Montana, Nevada, Oklahoma, and Texas, have been approved for the federal incentive.[43] Should Wyoming choose to amend the State False Claims Act and succeed in qualifying for the incentive, the federal share of Medicaid dollars recovered under the Act would be reduced from 50 percent to 40 percent, and the State share of such dollars would increase from 50 percent to 60 percent.

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[42] **DHHS Office of Inspector General, State False Claims Act Reviews webpage, accessed August 2022**; and **NCSL, Incentivizing State False Claims Acts, Updated March 2013**.

[43] States with qualifying false claims acts: California, Colorado, Connecticut, Delaware, Georgia, Hawaii, Illinois, Indiana, Iowa, Massachusetts, Minnesota, Montana, Nevada, New York, North Carolina, Oklahoma, Rhode Island, Tennessee, Texas, Vermont, Virginia, and Washington.